Michigan Department of Community Health (MDCH) Comments and Recommendations for Certificate of Need (CON) Review Standards Scheduled for 2008 Review Presented to CON Commission January 24, 2008

HOSPITAL BEDS (Please refer to MDCH staff summary of comments for additional detail - attached)			
All Identified Issues	Issue Recommended for Review?	Recommended Course of Action to Review Issues	Other/Comments
1. Continued regulation of Hospital Beds under CON.	N/A		Hospital Beds are not a covered clinical service. Therefore, de-regulation of Hospital Beds is not up for consideration.
2. Review comparative review criteria because 45% of the possible points in a comparative review are determined by payor mix.	No	None at this time	Thoroughly discussed with the last revisions (effective 3/8/07).
3. Replacement of existing licensed hospital beds to new physical plant space and the scope of the current hospital replacement zone.	No	None at this time	MDCH has completed review of information and comments submitted subsequent to the 2007 activity on this topic. There is no new or emerging information of a compelling nature that would necessitate additional action during this review cycle.
4. Modifications to allow for freestanding long-term (acute) care hospitals (LTACHs) that would operate as separate and distinct facilities outside the physical plant of an existing hospital.	No	None at this time	This issue should be addressed in conjunction with the next scheduled review of hospital bed standards.
5. CON standards review cycle and data suggestions for all CON review standards.	No	None at this time	Take the data suggestions under advisement with the review of each standard.
6. Make technical changes and updates that provide uniformity in all CON	Yes	Draft language, which includes re-calculation of the bed need	The Department will re-calculate the bed need numbers as

standards; i.e. Medicaid, revisions to reference of on-line system; make additional technical changes under Sections 2 and 6; re-calculate bed need numbers		numbers, will be developed by MDCH staff	soon as the 2006 MIDB data is obtained.
Recommendation: The Department recommends that the Commission assign responsibility to Department staff to draft technical changes and re-calculate the bed need numbers (#6) for appropriate Commission review and public comment.			

HOSPITAL BEDS

Summary of 10/31/07 Public Hearing Comments and Department Comments – Working Document
Prepared by: MDCH

Considerations from 10/31/07 Public Hearing.	
Public Hearing Summary: The complete oral and written testimonies are included in the January 24, 2008 CON Commission meeting binders. The agencies represented were as follows: • Spectrum Health (Written): The current standards are reasonable and have served the state well - no major changes need to be made. • William Beaumont Hospital (Written): Comparative review criteria should be reviewed by the Commission because 45% of the possible points in a comparative review are determined by payor mix. • Oakwood Healthcare, Inc. (Written): Replacement of existing licensed hospital beds to new physical plant space and the scope of the current hospital replacement zone need to be reviewed. • Northern Michigan Regional Hospital (Written): Modifications to allow for freestanding long-term (acute) care hospitals that would operate as separate and distinct facilities outside the physical plant of an existing hospital. • Economic Alliance for Michigan (Verbal and Written): 1) Recommends that the next review be scheduled for 2009, not 2010, with no review in 2008. 2) All CON review standards that rely upon data should automatically use the most currently available data from either the MIDB or the MDCH Annual Surveys with annual updates of the data being done no later than 60 to 90 days following receipt of the data. 3) Every CON review standard that requires a projection of minimum volumes to justify a new program should be based on actual, historical referral data and not based upon the unverifiable projections of future referrals. 4) Organizations/providers seeking to start a new CON-approved program should not use any data to support their application that would result in a current CON-approved program falling below the CON minimum volume for that service. MDCH: 1) Add language under Section 1, Applicability, for Medicaid (technical change being made throughout the CON review standards). 2) Re-calculate bed need numbers. 3) Other technical changes.	***Policy Issues to be Addressed*** Recognizing the aging of the hospitals in Michigan, the Department could recommend taking another look at replacement of existing licensed hospital beds to new physical plant space and the scope of the current hospital replacement zone. This could be done by the Department with a workgroup or with Standard Advisory Committee (SAC). Modifications to allow for freestanding long-term (acute) care hospitals that would operate as separate and distinct facilities outside the physical plant of an existing hospital needs further review. Again, this could be done by the Department with a workgroup or with a SAC. The technical changes, including re-calculation of the bed need numbers, would be drafted by the Department and would be included in the final recommendation to the Commission. If the Commission chooses to only address the technical changes and re-calculation of the bed need numbers, the Department would draft the language for proposed action for the Commission's September 16, 2008 meeting. The Department recommends no change to the CON standards review cycle. Maintaining a set schedule for the review of CON standards is administratively feasible. As far as the proposed recommendations regarding the data (for all standards), the Department suggests taking this under advisement with the review of each standard. Therefore, no change recommended, unless applicable to a standard under current review. A more detailed analysis is included on the following pages.

1. Review comparative review criteria because 45% of the possible points in a comparative review are determined by payor mix. Note: Consideration from 10/31/08 Public Hearing.	
Current Standards Sec. 13(3)(a) and (b) (Applicants not in Limited Access Areas): (3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's uncompensated care volume and as measured by percentage of gross hospital revenues as set forth in the following table. The applicant's uncompensated care volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the Department for purposes of calculating disproportionate share hospital payments. <u>Percentile Ranking Points Awarded</u> 90.0 – 100 25 pts 80.0 – 89.9 20 pts 70.0 – 79.9 15 pts 60.0 – 69.9 10 pts 50.0 – 59.9 5 pts Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation. (b) A qualifying project will be awarded points based on the health service area percentile rank of the applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant that are located in the same health service area as the proposed hospital beds. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero. The source document for the calculation shall be the most recent Cost Report filed with the department for purposes of calculating disproportionate share hospital payments. <u>percentile rank points awarded</u> 87.5 – 100 20 pts 75.0 – 87.4 15 pts 62.5 – 74.9 10 pts 50.0 – 61.9 5 pts less than 50.0 0 pts Where an applicant proposes to close a hospital(s) as part of its application, data from the hospital(s) to be closed shall be excluded from this calculation.	***Policy Perspective*** This was thoroughly discussed with the last revisions (effective 3/8/07), and the statutory requirement, MCL 333.22230, mandates "In evaluating applications for a health facility as defined under section 22205(1)(c) in a comparative review, the department shall include participation in title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v, as a distinct criterion, weighted as very important, and determine the degree to which an application meets this criterion based on the extent of participation in the medicaid program." No change is recommended at this time.

Sec. 14(3)(a) and (b) (Applicants in Limited Access Areas):

(3)(a) A qualifying project will be awarded points based on the percentile ranking of the applicant's uncompensated care volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's uncompensated care will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source document for the calculation shall be the most recent Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

Percentile Ranking	Points Awarded
90.0 – 100	25 pts
80.0 – 89.9	20 pts
70.0 – 79.9	15 pts
60.0 – 69.9	10 pts
50.0 – 59.9	5 pts

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

(b) A qualifying project will be awarded points based on the statewide percentile rank of the applicant's Medicaid volume as measured by percentage of gross hospital revenues as set forth in the following table. For purposes of scoring, the applicant's Medicaid volume will be the cumulative of all currently licensed Michigan hospitals under common ownership or control with the applicant. The source documents for the calculation shall be the Cost Report submitted to MDCH for purposes of calculating disproportionate share hospital payments. If a hospital under common ownership or control with the applicant has not filed a Cost Report, then the related applicant shall receive a score of zero.

Percentile Rank	Points Awarded
87.5 – 100	20 pts
75.0 – 87.4	15 pts
62.5 – 74.9	10 pts
50.0 – 61.9	5 pts
Less than 50.0	0 pts

Where an applicant proposes to close a hospital as part of its application, data from the closed hospital shall be excluded from this calculation.

2. Replacement of existing licensed hospital beds to new physical plant space and the scope of the current hospital replacement zone. Note: Consideration from 10/31/07 Public Hearing.

Current Standards

Sec. 2(1):

(dd) "New beds in a hospital" means hospital beds that meet at least one of the following: (i) are not currently licensed as hospital beds, (ii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for

Policy Perspective

The current CON review for standards for hospital beds allow for replacement of facilities. The issue identified in testimony is the same that has been reviewed several times in the past – limitations of the size of the replacement zone.

relocation in a different subarea as determined by the Department pursuant to Section 3 of these standards, (iii) are currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) are currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with Section 6(2) of these standards. (ee) "New hospital" means one of the following: (i) the establishment of a new facility that shall be issued a new hospital license, (ii) for currently licensed beds, the establishment of a new licensed site that is not in the same hospital subarea as the currently licensed beds, (iii) currently licensed hospital beds at a licensed site in one subarea which are proposed for relocation to another geographic site which is in the same subarea as determined by the Department, but which are not in the replacement zone, or (iv) currently licensed hospital beds that are proposed to be licensed as part of a new hospital in accordance with section 6(2) of these standards. (ll) "Relocate existing licensed hospital beds" for purposes of sections 6(3) and 8 of these standards, means a change in the location of existing hospital beds from the existing licensed hospital site to a different existing licensed hospital site within the same hospital subarea or HSA. This definition does not apply to projects involving replacement beds in a hospital governed by Section 7 of these standards. (nn) "Replacement beds in a hospital" means hospital beds that meet all of the following conditions; (i) an equal or greater number of hospital beds are currently licensed to the applicant at the licensed site at which the proposed replacement beds are currently licensed; (ii) the hospital beds are proposed for replacement in new physical plant space being developed in new construction or in newly acquired space (purchase, lease, donation, etc.); and (iii) the hospital beds to be replaced will be located in the replacement zone. (oo) "Replacement zone" means a proposed licensed site that is (i) in the same subarea as the existing licensed site as determined by the Department in accord with Section 3 of these standards and (ii) on the same site, on a contiguous site, or on a site within 2 miles of the existing licensed site if the existing licensed site is located in a county with a population of 200,000 or more, or on a site within 5 miles of the existing licensed site if the existing licensed site is located in a county with a population of less than 200,000. **Section 7. Requirements for approval -- replacement beds in a hospital in a replacement zone** Sec. 7. (1) If the application involves the development of a new licensed site, an applicant proposing replacement beds in a hospital in the replacement zone shall demonstrate that the new beds in a hospital shall result in a hospital of at least 200 beds in a metropolitan statistical area county or 50 beds in a rural or micropolitan statistical area county. This subsection may be waived by the Department if the Department determines, in its sole discretion, that a smaller hospital is necessary or appropriate to assure access to health-care services.	Since 2004, two SACs and a Department workgroup have reviewed this issue. The latest report was presented to the Commission in March 2007. At that time, the following determinations were made: • "While there is considerable information that "green" technology can provide cost savings, this information does not by itself lead to the conclusion that there is a need to rebuild hospitals outside of the replacement zone. • Hospitals are generally available statewide and access greater than 30 minutes travel time does not appear to be a problem for the state. • A combination of the other data available to the department at this time requires the conclusion that a change in standards is not necessary. • The Department has not yet however, received detailed information supporting the specific proposals for individual hospitals who wish to move. In summary, the Department has completed its review of the currently available information. As is always the case with CON, further future review in response to new or emerging information of a compelling nature may be necessary during the next regular statutory review of the hospital beds need methodology." In 2005, Michigan's beds per 1,000 population was 2.6 (this has remained constant since 2000), while the national average per 1,000 population was 2.7 (this has slowly declined since 2000)*. This would lead one to believe that the actual number of beds in Michigan is consistent with the nation. However, since Michigan's hospitals are continuing to age, and no specific recommendations have been identified for replacement within the current replacement zone if there are barriers, i.e., landlocked, some alternatives that could be explored, in addition to what has been previously looked at, include: • Consideration of language that would allow for replacement outside the replacement zone, but still within the same subarea as long as there is a bed need for that subarea (similar to the Nursing Home and Hospital Long-term Care). • Have MSU Geography Department (or other entity) look at other alternatives to identify need and/or placement of hospitals within the State of Michigan. Further review of the issue could be considered.

(2) In order to be approved, the applicant shall propose to (i) replace an equal or lesser number of beds currently licensed to the applicant at the licensed site at which the proposed replacement beds are located, and (ii) that the proposed new licensed site is in the replacement zone. (3) An applicant proposing replacement beds in the replacement zone shall not be required to be in compliance with the needed hospital bed supply set forth in Appendix C if the application meets all other applicable CON review standards and agrees and assures to comply with all applicable project delivery requirements.	*Source: National Directory State Certificate of Need Programs Health Planning Agencies 2007
3. Modifications to allow for freestanding long-term (acute) care hospitals (LTACHs)that would operate as separate and distinct facilities outside the physical plant of an existing hospital. Note: Consideration from 10/31/07 Public Hearing.	
Current Standards Sec. 6(2): (2) An applicant proposing to begin operation as a new long-term (acute) care hospital or alcohol and substance abuse hospital within an existing licensed, host hospital shall demonstrate that it meets all of the requirements of this subsection: (a) If the long-term (acute) care hospital applicant described in this subsection does not meet the Title XVIII requirements of the Social Security Act for exemption from PPS as a long-term (acute) care hospital within 12 months after beginning operation, then it may apply for a six-month extension in accordance with R325.9403 of the CON rules. If the applicant fails to meet the Title XVIII requirements for PPS exemption as a long-term (acute) care hospital within the 12 or 18-month period, then the CON granted pursuant to this section shall expire automatically. (b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following: (i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital. (ii) That the proposed new beds shall be for use in space currently licensed as part of the host hospital. (iii) That upon non-renewal and/or termination of the lease, upon termination of the license issued under Part 215 of the act to the applicant for the new hospital, or upon noncompliance with the project delivery requirements or any other applicable requirements of these standards, the beds licensed as part application to replace the fixed units is submitted to the Department. (vi) The proposed mobile UESWL unit is projected to perform at least of the new hospital must be disposed of by one of the following means: (A) Relicensure of the beds to the host hospital. The host hospital must obtain a CON to acquire the long-term (acute) care hospital. In the event that	***Policy Perspective*** The current standards allow for freestanding LTACHs provided that there is a bed need in the subarea. Further, the existing language only allows for the use of existing beds from a hospital to set up a LTACH within that host hospital. The question is should you be able to use existing beds from a hospital(s) to set up a freestanding LTACH (the physical relocation of beds from a licensed site to another geographic location). The physical relocation of beds from a licensed site to another geographic location could also be tied to the replacement issue if it is allowed. Needs further review.

the host hospital applies for a CON to acquire the long-term (acute) care hospital [including the beds leased by the host hospital to the long-term (acute) care hospital] within six months following the termination of the lease with the long-term (acute) care hospital, it shall not be required to be in compliance with the hospital bed supply set forth in Appendix C if the host hospital proposes to add the beds of the long-term (acute) care hospital to the host hospital's medical/surgical licensed capacity and the application meets all other applicable project delivery requirements. The beds must be used for general medical/surgical purposes. Such an application shall not be subject to comparative review and shall be processed under the procedures for non-substantive review (as this will not be considered an increase in the number of beds originally licensed to the applicant at the host hospital); (B) Delicensure of the hospital beds; or (C) Acquisition by another entity that obtains a CON to acquire the new hospital in its entirety and that entity must meet and shall stipulate to the requirements specified in Section 6(2). (c) The applicant or the current licensee of the new hospital shall not apply, initially or subsequently, for CON approval to initiate any other CON covered clinical services; provided, however, that this section is not intended, and shall not be construed in a manner which would prevent the licensee from contracting and/or billing for medically necessary covered clinical services required by its patients under arrangements with its host hospital or any other CON approved provider of covered clinical services. (d) The new licensed hospital shall remain within the host hospital. (e) The new hospital shall be assigned to the same subarea as the host hospital. (f) The proposed project to begin operation of a new hospital, under this subsection, shall constitute a change in bed capacity under Section 1(3) of these standards. (g) The lease will not result in an increase in the number of licensed hospital beds in the subarea. (h) Applications proposing a new hospital under this subsection shall not be subject to comparative review.	
4. CON standards review cycle and data suggestions for all CON review standards. Note: Consideration from 10/31/07 Public Hearing.	
Current Standards Sections vary under each set of CON review standards.	***Policy Perspective*** Maintaining a set schedule for the review of CON standards is administratively feasible, and it allows for a more consistent review of the standards. No change recommended. As far as the proposed recommendations regarding the data (for all standards), the Department suggests taking this under advisement with the review of each standard. Each set of CON review standards has applicable sections that would have to be reviewed and potentially modified. Each set of standards would still need to go through the formal process of proposed

	action, public hearing, and final action. Therefore, no change recommended, unless applicable to a standard under current review.
5. Other technical changes. Note: Consideration from MDCH.	
Current Standards Add new subsection under Section 1 for Medicaid applicability. **Section 2(1)(a), (t), & (u)** (a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a hospital with a valid license and which does not involve a change in bed capacity. (t) "Host hospital," for purposes of these standards, means an existing licensed hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation. (u) "Licensed site" means either (i) in the case of a single site hospital, the location of the facility authorized by license and listed on that licensee's certificate of licensure or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure. **Section 6(2)(b) & (b)(i)** (b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following: (i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital. **Section 17. Requirements for approval – all applicants** Sec. 17. An applicant shall provide verification of Medicaid participation at the time the application is submitted to the Department. An applicant that is a new provider not currently enrolled in Medicaid shall provide a signed affidavit stating that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved. If the required documentation is not submitted with the application on the designated application date, the application will be deemed filed on the first applicable designated application date after all required documentation is received by the Department. Section 9(2): (2) The agreements and assurances required by this section shall be in	***Policy Perspective*** Technical changes being made throughout the CON review standards to accommodate the CON application on-line system and for consistency throughout the standards as applicable. Additional technical changes for clarity under sections 2 and 6 as follows (consistent with Department practice and policy): **Section 2(1)(a), (t), & (u)** (a) "Acquiring a hospital" means the issuance of a new hospital license as the result of the acquisition (including purchase, lease, donation, or other comparable arrangements) of a ~~hospital with a valid~~ licens~~e~~d AND OPERATING HOSPITAL and which does not involve a change in bed capacity. (t) "Host hospital," for purposes of these standards, means a~~n existing~~ licensed AND OPERATING hospital, which delicenses hospital beds, and which leases patient care space and other space within the physical plant of the host hospital, to allow a long-term (acute) care hospital, or alcohol and substance abuse hospital, to begin operation. (u) "Licensed site" means ~~either (i) in the case of a single site hospital,~~ the location of the facility authorized by license and listed on that licensee's certificate of licensure~~ or (ii) in the case of a hospital with multiple sites, the location of each separate and distinct inpatient unit of the health facility as authorized by license and listed on that licensee's certificate of licensure~~. **Section 6(2)(b) & (b)(i)** (b) The patient care space and other space to establish the new hospital is being obtained through a lease arrangement AND RENEWAL OF A LEASE between the applicant and the host hospital. The initial, renewed, or any subsequent lease shall specify at least all of the following: (i) That the host hospital shall delicense the same number of hospital beds proposed by the applicant for licensure in the new hospital OR ANY SUBSEQUENT APPLICATION TO ADD ADDITIONAL BEDS. The Commission needs to ask the Department to re-calculate the acute care bed need methodology to be completed by September 2008. The Department suggests the base year as 2006 and the planning year as 2011. The last re-

the form of a certification authorized by the governing body of the applicant or its authorized agent. **Section 5. Bed Need** Sec. 5. (1) The bed-need numbers incorporated as part of these standards as Appendix C shall apply to projects subject to review under these standards, except where a specific CON review standard states otherwise. (2) The Commission shall direct the Department, effective November 2004 and every two years thereafter, to re-calculate the acute care bed need methodology in Section 4, within a specified time frame. (3) The Commission shall designate the base year and the future planning year which shall be utilized in applying the methodology pursuant to subsection (2). (4) When the Department is directed by the Commission to apply the methodology pursuant to subsection (2), the effective date of the bed-need numbers shall be established by the Commission. (5) As directed by the Commission, new bed-need numbers established by subsections (2) and (3) shall supersede the bed-need numbers shown in Appendix C and shall be included as an amended appendix to these standards. Section 2(1): (c) "Base year" means the most recent year that final MIDB data is available to the Department unless a different year is determined to be more appropriate by the Commission. (ii) "Planning year" means five years beyond the base year, established by the CON Commission, for which hospital bed need is developed, unless a different year is determined to be more appropriate by the Commission.	run (effective September 19, 2006) used 2005 as the base year and 2010 as the planning year. Note: the Department will not be able to re-calculate until we receive the 2006 MIDB data.